STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
MICHIGAN

LIST OF TABLES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
MICHIGAN, 2003

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)		Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries (Cell)	
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	1,594,249	(A)	230,327	(E)	1,363,922	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1,552,798	(B)	214,560	(F)	1,338,238	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	937,991	(C)	209,013	(G)	728,978	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	25,019	(D)	23,608	(H)	1,411	(L)

Source: Data for this table are from the MAX 2003 file for Michigan, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. MAX data element "Eligible Months Count" was used to determine an individual's Medicaid eligibility. All individuals who had a value greater than zero were considered as beneficiaries and counted in Cell A.

b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2003 (based on MAX data element "Eligible Restricted Benefits Flag").

c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2003, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.

d. The total Medicaid pharmacy reimbursement for Michigan in 2003 was $749,842,182, of which $103,795,584 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 19 states in 2003 that had PHPs that did not include a pharmacy benefit: AL, AR, CA, CO, FL, GA, IA, KY, MA, MI, NY, OR, PA, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit: DE, IA, NE, NY, TX, UT, and WV. These lists were constructed from the CMS 2003 Medicaid Managed Care Enrollment Report [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer02.pdf] and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2003. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the benficiary had a fee-for-service pharmacy benefit.

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2003. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

Characteristics of non-dual eligible beneficiaries represented by Cell J are shown in Appendix Table A.1 and characteristics of non-dual eligible beneficiaries and their benefit months included in Cell J but excluded from Cell K are shown in Appendix Table A.2. Characteristics of dual eligible beneficiaries represented by Cell F are shown in Appendix Table A.3, and characteristics of dual eligible beneficiaries and their benefit months included in Cell F but excluded from Cell G are shown in Appendix Table A.4.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; HMO = health maintenance organization; MAX = Medicaid Analytic Extract; MC = managed care; PCCM = primary care case management; PHP = prepaid health plan.

TABLE 2

CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]

MICHIGAN, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**937,991**	**93,897**	**183,145**	**184,290**	**476,659**	**0**	**5,655,196**	**937,522**	**1,658,013**	**781,125**	**2,278,536**	**0**
Age												
5 and younger	205,099	0	4,538	2,098	198,463	0	947,499	0	36,085	10,313	901,101	0
6-14	207,632	0	9,881	1,769	195,982	0	1,047,778	0	74,730	8,486	964,562	0
15-20	108,242	0	7,560	21,498	79,184	0	579,363	0	59,095	117,006	403,262	0
21-44	207,851	0	60,279	144,730	2,842	0	1,152,034	0	545,398	597,738	8,898	0
45-64	89,409	16	75,274	14,085	34	0	713,022	102	665,882	46,966	72	0
65-74	47,474	27,315	20,062	95	2	0	496,226	280,458	215,228	533	7	0
75-84	41,082	36,558	4,514	10	0	0	423,459	372,720	50,672	67	0	0
85 and older	31,045	30,007	1,037	1	0	0	295,158	284,233	10,923	2	0	0
Unknown	157	1	0	4	152	0	657	9	0	14	634	0
Gender												
Female	543,710	69,515	95,682	144,623	233,890	0	3,350,513	703,056	887,022	647,807	1,112,628	0
Male	394,281	24,382	87,463	39,667	242,769	0	2,304,683	234,466	770,991	133,318	1,165,908	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Race												
White	599,507	66,992	118,695	118,712	295,108	0	3,828,672	659,647	1,104,801	525,925	1,538,299	0
African American	260,391	17,721	54,128	52,966	135,576	0	1,367,073	182,476	458,499	200,435	525,663	0
Other/unknown	78,093	9,184	10,322	12,612	45,975	0	459,451	95,399	94,713	54,765	214,574	0
Use of Nursing Facilities[c]												
Entire year	25,019	21,645	3,373	1	0	0	261,485	223,899	37,585	1	0	0
Part year	18,222	14,757	3,441	22	2	0	164,784	132,886	31,752	131	15	0
None	894,750	57,495	176,331	184,267	476,657	0	5,228,927	580,737	1,588,676	780,993	2,278,521	0
Maintenance Assistance Status												
Cash	228,318	20,169	102,153	38,579	67,417	0	1,596,303	228,083	971,410	157,647	239,163	0
Medically needy	79,923	8,314	9,491	42,421	19,697	0	350,221	66,820	60,066	147,890	75,445	0
Poverty-related	318,265	2,476	3,446	33,717	278,626	0	1,643,011	25,462	32,748	201,843	1,382,958	0
Other/unknown	311,485	62,938	68,055	69,573	110,919	0	2,065,661	617,157	593,789	273,745	580,970	0
Dual Medicare Status[d]												
Full dual, all year	198,737	85,725	111,383	1,582	47	0	2,054,400	867,984	1,177,922	8,207	287	0
Full dual, part year	10,276	4,658	5,599	19	0	0	102,848	47,888	54,777	183	0	0
Non-dual, all year	728,978	3,514	66,163	182,689	476,612	0	3,497,948	21,650	425,314	772,735	2,278,249	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	475,926	93,364	139,029	75,027	168,506	0	4,014,637	933,675	1,459,734	419,426	1,201,802	0
FFS part year, with Rx claims	176,543	418	31,795	58,321	86,009	0	752,246	3,192	152,496	225,145	371,413	0
FFS part year, no Rx claims	285,522	115	12,321	50,942	222,144	0	888,313	655	45,783	136,554	705,321	0

Source: Data for this table are from the MAX 2003 file for Michigan, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 2 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services. The total includes some beneficiaries with unknown basis of eligibility and some whose age categories are not consistent with basis of eligibility.

c. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2003. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service pharmacy benefit; MAX = Medicaid Analytic Extract; MC = managed care; Rx = pharmacy benefit.

TABLE 3

ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC[a, b]

MICHIGAN, 2003

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**50.9 %**	**12.5**	**$689**	**$55**	**$4,444**	**15.5 %**	**937,991**
Age							
5 and younger	35.1	1.3	51	38	1,859	2.7	205,099
6-14	31.0	2.2	169	75	1,201	14.1	207,632
15-20	41.3	3.3	214	65	1,868	11.5	108,242
21-44	59.4	10.0	710	71	4,427	16.0	207,851
45-64	77.2	33.6	2,116	63	9,878	21.4	89,409
65-74	85.7	45.1	2,166	48	7,622	28.4	47,474
75-84	87.2	48.2	2,062	43	12,871	16.0	41,082
85 and older	88.1	45.9	1,709	37	20,666	8.3	31,045
Unknown	0.6	0.0	0	7	28	0.2	157
Basis of Eligibility[e]							
Aged	85.8	45.3	1,901	42	14,040	13.5	93,897
Disabled	79.8	32.8	2,188	67	10,440	21.0	183,145
Adults	52.5	3.8	152	40	2,083	7.3	184,290
Children	32.3	1.6	81	51	1,163	7.0	476,659
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	54.9	14.7	735	50	4,737	15.5	543,710
Male	45.3	9.5	625	66	4,040	15.5	394,281
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	55.7	14.5	801	55	4,905	16.3	599,507
African American	41.9	9.0	495	55	3,711	13.3	260,391
Other/unknown	44.3	9.0	471	52	3,349	14.1	78,093
Use of Nursing Facilities[f]							
Entire year	95.2	67.2	2,684	40	39,506	6.8	25,019
Part year	94.0	52.4	2,144	41	23,281	9.2	18,222
None	48.8	10.2	603	59	3,080	19.6	894,750
Maintenance Assistance Status							
Cash	61.5	19.5	1,181	61	5,764	20.5	228,318
Medically needy	49.5	9.7	509	52	3,432	14.8	79,923
Poverty related	34.9	1.9	86	47	1,182	7.3	318,265
Other/unknown	59.9	19.0	989	52	7,068	14.0	311,485

Source: Data for this table are from the MAX 2003 file for Michigan, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 3 includes beneficiaries represented by Cell C of Table 1.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. In seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; OTC = over-the-counter; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 4

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT *PER BENEFIT MONTH*, BY BENEFICIARY CHARACTERISTIC[a, b]

MICHIGAN, 2003

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Number Beneficiaries	Benefit Months
All	**2.1**	**$114**	**15.5 %**	**49.1 %**	**25.8 %**	**6.0 %**	**10.0 %**	**6.8 %**	**2.3 %**	**$737**	**937,991**	**5,655,196**
Age												
5 and younger	0.3	11	2.7	64.9	31.5	2.3	1.0	0.1	0.0	402	205,099	947,499
6-14	0.4	34	14.1	69.0	23.2	3.2	2.9	1.0	0.6	238	207,632	1,047,778
15-20	0.6	40	11.5	58.7	31.0	4.8	3.8	1.1	0.5	349	108,242	579,363
21-44	1.8	128	16.0	40.6	31.3	9.1	11.4	5.4	2.3	799	207,851	1,152,034
45-64	4.2	265	21.4	22.8	16.4	9.9	24.1	19.3	7.4	1,239	89,409	713,022
65-74	4.3	207	28.4	14.3	15.4	10.4	28.9	24.5	6.5	729	47,474	496,226
75-84	4.7	200	16.0	12.8	12.3	9.5	30.4	27.7	7.3	1,249	41,082	423,459
85 and older	4.8	180	8.3	11.9	10.4	9.9	32.3	28.9	6.6	2,174	31,045	295,158
Unknown	0.0	0	0.2	99.4	0.6	0.0	0.0	0.0	0.0	7	157	657
Basis of Eligibility[e]												
Aged	4.5	190	13.5	14.2	13.0	9.9	29.9	26.3	6.8	1,406	93,897	937,522
Disabled	3.6	242	21.0	20.2	20.8	10.7	24.2	17.6	6.4	1,153	183,145	1,658,013
Adults	0.9	36	7.3	47.5	34.1	7.7	6.9	2.5	1.3	491	184,290	781,125
Children	0.3	17	7.0	67.7	27.0	2.8	1.8	0.5	0.2	243	476,659	2,278,536
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.4	119	15.5	45.1	26.6	6.4	11.1	8.1	2.8	769	543,710	3,350,513
Male	1.6	107	15.5	54.7	24.6	5.5	8.5	5.1	1.6	691	394,281	2,304,683
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.3	126	16.3	44.3	27.4	6.4	11.0	8.0	2.9	768	599,507	3,828,672
African American	1.7	94	13.3	58.1	22.1	5.3	8.3	4.8	1.3	707	260,391	1,367,073
Other/unknown	1.5	80	14.1	55.7	25.7	5.2	7.7	4.5	1.2	569	78,093	459,451
Use of Nursing Facilities[f]												
Entire year	6.4	257	6.8	4.8	5.4	6.4	29.5	38.8	15.1	3,780	25,019	261,485
Part year	5.8	237	9.2	6.0	7.7	8.9	32.4	33.7	11.3	2,574	18,222	164,784
None	1.7	103	19.6	51.2	26.7	5.9	9.0	5.4	1.8	527	894,750	5,228,927
Maintenance Assistance Status												
Cash	2.8	169	20.5	38.5	24.0	8.2	15.5	10.3	3.5	824	228,318	1,596,303
Medically needy	2.2	116	14.8	50.5	21.8	7.3	11.1	7.0	2.4	783	79,923	350,221
Poverty related	0.4	17	7.3	65.1	29.5	2.8	1.8	0.5	0.2	229	318,265	1,643,011
Other/unknown	2.9	149	14.0	40.1	24.3	7.3	14.1	10.6	3.5	1,066	311,485	2,065,661

Source: Data for this table are from the MAX 2003 file for Michigan, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 4 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. In seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 5

AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC[a, b, c]

MICHIGAN, 2003

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**2.1**	**$114**	**$55**	**0.8**	**$90**	**$106**	**0.0**	**$2**	**$48**	**1.2**	**$22**	**$18**
Age												
5 and younger	0.3	11	38	0.1	8	81	0.0	0	62	0.2	3	14
6-14	0.4	34	75	0.3	29	114	0.0	1	87	0.2	4	20
15-20	0.6	40	65	0.3	33	111	0.0	1	79	0.3	6	19
21-44	1.8	128	71	0.7	102	141	0.0	3	73	1.0	22	21
45-64	4.2	265	63	1.7	209	125	0.1	6	61	2.4	49	20
65-74	4.3	207	48	1.8	162	92	0.1	3	34	2.5	42	17
75-84	4.7	200	43	1.9	154	81	0.1	3	26	2.7	43	16
85 and older	4.8	180	37	1.9	134	73	0.1	3	22	2.8	42	15
Unknown	0.0	0	7	0.0	0	0	0.0	0	0	0.0	0	7
Basis of Eligibility[d]												
Aged	4.5	190	42	1.8	146	80	0.1	3	25	2.6	41	16
Disabled	3.6	242	67	1.5	193	129	0.1	6	64	2.0	43	21
Adults	0.9	36	40	0.3	27	88	0.0	1	37	0.6	8	14
Children	0.3	17	51	0.2	14	87	0.0	0	68	0.2	3	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.4	119	50	1.0	93	97	0.1	2	40	1.4	24	17
Male	1.6	107	66	0.7	86	125	0.0	3	67	0.9	19	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.3	126	55	0.9	99	105	0.1	3	47	1.3	23	19
African American	1.7	94	55	0.6	74	114	0.0	2	52	1.0	19	18
Other/unknown	1.5	80	52	0.6	63	99	0.0	2	53	0.9	15	18
Use of Nursing Facilities[e]												
Entire year	6.4	257	40	2.5	194	76	0.2	4	23	3.7	59	16
Part year	5.8	237	41	2.2	179	80	0.2	4	27	3.4	54	16
None	1.7	103	59	0.7	82	114	0.0	2	56	1.0	19	19
Maintenance Assistance Status												
Cash	2.8	169	61	1.1	135	118	0.1	3	52	1.6	31	20
Medically needy	2.2	116	52	0.9	91	101	0.1	3	55	1.3	22	18
Poverty related	0.4	17	47	0.2	13	86	0.0	0	58	0.2	3	15
Other/unknown	2.9	149	52	1.2	117	100	0.1	3	44	1.6	29	18

Source: Data for this table are from the MAX 2003 file for Michigan, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 5 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Michigan, 0.3 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007)

d. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

e. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 6

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY[a, b, c, d]

MICHIGAN, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$16	$13	$0	$3	$56	$111	$83	$18	670,678	$37,691,106	259,671	27.7 %	2,301,066
Biologicals	1.0	0.1	0.1	0.7	####	133	360	####	2742	1,100	2,641	3,029	890	2,440,419	88	0.0	894
Antineoplastic Agents	0.5	0.2	0.0	0.3	103	82	1	19	221	439	110	72	45,346	10,003,312	9,615	1.0	97,073
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	33	26	1	6	42	77	20	15	1,102,666	45,859,829	144,932	15.5	1,371,389
Cardiovascular Agents	1.6	0.5	0.0	1.1	51	33	1	17	31	66	49	15	2,594,357	80,421,607	158,228	16.9	1,583,647
Respiratory Agents	0.6	0.3	0.0	0.2	32	27	1	4	55	80	79	17	754,207	41,593,678	138,224	14.7	1,281,120
Gastrointestinal Agents	0.6	0.4	0.0	0.3	43	38	1	5	67	107	163	18	737,095	49,448,858	114,287	12.2	1,138,714
Genitourinary Agents	0.4	0.3	0.0	0.1	25	23	0	1	57	69	40	16	197,775	11,339,352	45,990	4.9	457,600
CNS Drugs	1.2	0.6	0.0	0.6	102	86	1	14	82	139	140	23	1,986,210	162,354,100	183,273	19.5	1,596,209
Stimulants/Anti-obesity/Anorexia	0.9	0.6	0.0	0.3	51	43	1	8	58	69	63	31	149,346	8,619,693	24,237	2.6	167,414
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	81	79	0	2	133	137	89	62	91,988	12,227,159	14,672	1.6	151,010
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	32	23	0	8	46	138	98	15	1,258,044	57,637,644	198,469	21.2	1,812,518
Neuromuscular Agents	1.0	0.5	0.0	0.4	67	54	2	12	71	116	43	26	875,557	61,972,630	98,247	10.5	918,961
Nutritional Products	0.5	0.0	0.0	0.4	6	0	0	6	13	15	13	13	320,914	4,290,827	73,874	7.9	700,260
Hematological Agents	0.7	0.3	0.0	0.4	70	62	1	7	101	221	24	18	352,502	35,470,700	49,622	5.3	507,866
Topical Products	0.4	0.1	0.0	0.2	12	8	0	4	35	63	44	18	527,004	18,275,103	158,374	16.9	1,484,821
Miscellaneous Products	0.4	0.2	0.0	0.2	50	37	5	7	133	239	184	37	35,890	4,781,144	9,643	1.0	96,099
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	12	0	0	0	59	0	0	0	27,531	1,619,437	13,735	1.5	133,445
TOTAL NO. OF RX AND RX $	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	11,728,000	646,046,598	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Michigan, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 6 includes the beneficiaries represented by Cell C of Table 1. A beneficiary who used drugs from two or more categories was counted as a user for each category. Therefore, the sum of users across categories may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Michigan, 0.3 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2003.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; CNS = Central Nervous System; MAX = Medicaid Analytic Extract; n.a. = not applicable; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 7

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP[a, b, c]

MICHIGAN, 2003

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$94,510,004	73,846	7.9 %	777,090	0.7	$169	$122
ANTICONVULSANT	49,417,999	71,194	7.6	748,155	0.8	85	66
ANTIDEPRESSANTS	43,556,071	126,128	13.4	1,266,004	0.6	58	34
ULCER DRUGS	38,795,711	115,022	12.3	1,169,616	0.5	72	33
ANALGESICS - Narcotic	30,643,858	194,134	20.7	1,843,643	0.4	39	17
ANTIHYPERLIPIDEMIC	29,421,999	60,601	6.5	643,268	0.6	74	46
ANTIDIABETIC	27,696,992	79,931	8.5	817,981	0.7	51	34
ANTIASTHMATIC	27,483,440	143,449	15.3	1,355,918	0.4	55	20
MISC. HEMATOLOGICAL	23,157,793	25,068	2.7	264,220	0.6	155	88
ANALGESICS - ANTI-INFLAMMATORY	21,363,422	117,282	12.5	1,118,768	0.3	55	19
Total	386,047,289	1,006,655		10,004,663	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Michigan, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2003. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2003. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.